Independent Auditor's Report and
Financial Statements with Supplementary Schedules

COMMUNITY MEDICAL CENTERS, INC.

June 30, 2012 and 2011

FHG PARTNERS, LLP
CERTIFIED PUBLIC ACCOUNTANTS

COMMUNITY MEDICAL CENTERS, INC.

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FHG PARTNERS, LLP
CERTIFIED PUBLIC ACCOUNTANTS

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INDEPENDENT AUDITOR'S REPORT ON FINANCIAL STATEMENTS AND SUPPLEMENTARY SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS

Board of Directors
Community Medical Centers, Inc.
Stockton, California

We have audited the accompanying balance sheet of Community Medical Centers, Inc., a non-profit organization, as of June 30, 2012 and 2011, and the related statements of operations and changes in net assets, and cash flows for the years then ended. These financial statements are the responsibility of Community Medical Centers, Inc.'s management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Community Medical Centers, Inc.'s internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and the significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements referred to previously present fairly, in all material respects, the financial position of Community Medical Centers, Inc. as of June 30, 2012 and 2011, and the results of its activities, the changes in its net assets, and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

In accordance with *Government Auditing Standards*, we have also issued our report dated November 5, 2012, on our consideration of Community Medical Centers, Inc.'s internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our audit.

Our audit was conducted for the purpose of forming an opinion on the basic financial statements of Community Medical Centers, Inc. taken as a whole. The accompanying schedule of expenditures of federal awards is presented for purposes of additional analysis as required by U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments and Non-Profit Organizations*, and is not a required part of the basic financial statements. The schedule of expenditures of federal awards has been subjected to the auditing procedures applied in the audit of the basic financial statements and, in our opinion, is fairly stated in all material respects in relation to the basic financial statements taken as a whole.

FHG Partners, LLP

Visalia, California
November 5, 2012

COMMUNITY MEDICAL CENTERS, INC.
Balance Sheets
June 30, 2012 and 2011

	2012	2011
ASSETS		
Current Assets:		
Cash and cash equivalents	$ 3,675,501	$ 6,180,383
Short term investments	2,643,743	-
Assets limited as to use to meet current obligations	68,274	91,288
Patient accounts receivable, net	1,652,765	2,063,721
Grants and other receivables	1,729,072	695,372
Inventory	44,005	29,114
Prepaid expenses and deposits	748,056	779,140
Third-party settlements receivable	799,813	894,439
Total Current Assets	11,361,229	10,733,457
Assets limited as to use, less amount to meet current obligations	1,888,400	2,092,584
Bond issuance costs, net of accumulated amortization	133,029	146,522
Property, buildings, and equipment, net of accumulated depreciation	4,928,648	4,743,812
Total Assets	$18,311,306	$17,716,375
LIABILITIES AND NET ASSETS		
Current Liabilities:		
Accounts payable and accrued expenses	$ 609,015	$ 650,953
Accrued payroll and other related liabilities	3,956,949	3,836,729
Deferred revenue	98,777	263,694
Bank overdraft	258,208	-
Long-term debt, current portion	165,000	160,000
Total Current Liabilities	5,087,949	4,911,376
Long-term debt	2,120,000	2,285,000
Total Liabilities	7,207,949	7,196,376
Unrestricted net assets	11,103,357	10,519,999
Total Liabilities and Net Assets	$18,311,306	$17,716,375

See accompanying Notes to the Financial Statements

COMMUNITY MEDICAL CENTERS, INC.
Statements of Operations and Changes in Net Assets
Years ended June 30, 2012 and 2011

	2012	2011
Changes in unrestricted net assets:		
Revenue, grants, and other support:		
Patient service revenue, net	$ 27,153,790	$ 24,765,652
Capitated revenue	5,443,417	4,018,512
Grant revenue and other contributions	6,925,978	7,188,806
Electronic health records incentive program revenue	446,250	-
Other revenue	25,603	104,753
Total revenue, grants, and other support	39,995,038	36,077,723
Expenses:		
Salaries and wages	20,388,904	19,976,449
Employee benefits	4,175,428	4,298,723
Professional services	3,128,283	2,714,076
Purchased services	1,775,090	1,326,770
Supplies	2,600,251	2,422,157
Facilities	1,548,856	1,594,443
Printing, duplication, and postage	645,906	679,870
Depreciation	639,455	590,195
Insurance	151,525	152,709
Provision for bad debts	2,684,073	1,120,400
Communication	352,886	318,493
Utilities	220,687	197,350
Equipment, repairs, and maintenance	1,261,611	32,654
Travel, meetings, and training	478,844	485,741
Interest	130,300	136,739
Other	174,625	273,961
Total expenses	40,356,724	36,320,730
Deficiency of revenues over expenses	(361,686)	(243,007)
Capital grants and contributions	945,044	781,850
Increase in unrestricted net assets	583,358	538,843
Net Assets:		
Beginning of year	10,519,999	9,981,156
End of year	$ 11,103,357	$ 10,519,999

See accompanying Notes to the Financial Statements

COMMUNITY MEDICAL CENTERS, INC.
Statements of Cash Flows
Years ended June 30, 2012 and 2011

	2012	2011
Cash flows from operating activities:		
Increase in unrestricted net assets	$ 583,358	$ 538,843
Adjustments to reconcile operating income to net cash provided by operating activities:		
Provision for bad debts	2,684,073	1,120,400
Depreciation	639,455	590,195
Loss on disposal of property and equipment	1,271	370
Changes in operating assets and liabilities:		
Change in patient accounts receivable	(2,273,117)	(718,513)
Change in grants and other receivables	(1,033,700)	535,107
Change in inventory	(14,891)	373
Change in prepaid expenses and deposits	31,084	(195,328)
Change in third-party settlements receivable	94,626	156,289
Change in accounts payable and accrued expenses	(41,938)	220,003
Change in accrued payroll and other related liabilities	120,220	948,920
Changes in deferred revenue	(164,917)	(26,754)
Net cash provided by operating activities	625,524	3,169,905
Cash flows from investing activities:		
Long term investments	(2,643,743)	-
Acquisition of property, building, and equipment	(825,562)	(728,495)
Net cash used in investing activities	(3,469,305)	(728,495)
Cash flows from financing activities:		
Change in bond premium costs	13,493	13,493
Change in bank overdraft	258,208	-
Principal payment of long-term debt	(160,000)	(155,000)
Net cash provided by (used in) financing activities	111,701	(141,507)
Net increase (decrease) in cash and cash equivalents	(2,732,080)	2,299,903
Cash and cash equivalents, beginning of year	8,364,255	6,064,352
Cash and cash equivalents, end of year	$ 5,632,175	$ 8,364,255
Cash and cash equivalents	$ 3,675,501	$ 6,180,383
Assets limited as to use	1,956,674	2,183,872
	$ 5,632,175	$ 8,364,255
Short term investments	2,643,743	-
	$ 8,275,918	$ 8,364,255
Supplemental disclosure of cash flow information:		
Interest paid	$ 130,300	$ 136,739

See accompanying Notes to the Financial Statements

NOTE 1: ORGANIZATION AND OPERATIONS

Community Medical Centers, Inc. "the Center", a non-profit organization, was incorporated in 1978 for the purpose of rendering professional medical and health services to the needy, the impoverished, and the indigent, and those persons in socio-economic levels incapable of obtaining and receiving adequate medical care and treatment. The Center service area includes San Joaquin County, Solano County, and Yolo County in California.

The Center was designated as a Federally Qualified Health Center for Medicare and Medi-Cal reimbursement effective May 2000. The Center derives support through grants and contracts with the U.S. Department of Health and Human Services and the California Health and Human Services Agency. The majority of the revenue is derived from patients and the remainder from the aforementioned grants and contracts, as well as other state and local grants.

NOTE 2: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Cash and Cash Equivalents:
The Center considers all liquid investments with original maturities of three months or less to be cash equivalents. Effective July 31, 2010, the FDIC's insurance limits were permanently increased to $250,000 and all non-interest-bearing transactions accounts beginning December 31, 2010 through December 31, 2012 all fully insured at FDIC insured institutions. Of the cash and cash equivalents balance as of June 30, 2012, $1,696,265 was covered by federal depository insurance and $1,979,236 was uninsured. Of the cash balances as of June 30, 2011, $2,062,081 was covered by federal depository insurance and $4,118,302 was uninsured.

Assets Limited as to Use:
Assets limited as to use include bond reserve funds, 457(b) deferred compensation plan assets, donor-restricted funds, which are being held for specific purposes pursuant to donor stipulations, or other contracts, or board designated funds.

Patient Accounts Receivable:
Accounts receivable are recorded at gross value along with a corresponding allowance for doubtful accounts. Allowance accounts are estimated for each type of receivable based on the Center's experience in collecting receivables. Receivables are not collateralized. The Center does not refuse service to patients based on an individual's ability to pay.

Use of Estimates:
The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates. Management believes these estimates are reasonable.

Pharmacy Inventory:
Pharmaceutical Inventories are stated at the lower of cost, determined using the first-in, first-out method, or cost which approximates market value.

NOTE 2: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

Property, Building, and Equipment:
Property, building, and equipment are carried at cost or estimated fair value at date of acquisition. In the current year the Center updated its capitalization policy to comply with the maximum allowed Medicare capitalization amount. The Center's policy is to capitalize all acquisitions greater than $5,000 and with an economic useful life greater than one year.

Depreciation is calculated by the straight-line method over the estimated useful lives of the assets ranging from five to thirty years. Leasehold improvements are amortized on a straight-line method over the estimated useful life of the improvement or the term of the lease, whichever is less. Construction-in-progress is recorded at cost and is capitalized upon completion. Depreciation is recorded when construction is substantially complete and the assets are placed in service.

Certain property and equipment have been purchased with grant funds received from the U.S. Department of Health and Human Services and other government agencies. Such items or a portion thereof may be reclaimed by the grantor if not used to further the grantee's objective.

Donations of property and equipment are reported at their fair market value at the time the contributed asset is received as an increase in unrestricted net assets. Monetary gifts that must be used to acquire property and equipment are reported as restricted support. The expiration of such restrictions is reported as an increase in unrestricted net assets when the donated asset is placed in service.

Short Term Investments
The Center considers all investments with a maturity between three and twelve months as short term investments. Currently the Center's short term investments consist of primarily of certificates of deposits with maturity date ranging from September 2012 to July 2013. The certificate deposits are held with various financial institutions and are measured at fair value in the balance sheet. Investment revenue is comprised of interest income. Of the short term investment balances as of June 30, 2012, $2,639,000 was covered by federal depository insurance and $4,743 was uninsured.

Long-Lived Asset Impairment
The Center evaluates the recoverability of the carrying value of long-lived assets whenever events or circumstances indicate the carrying amount may not be recoverable. If a long-lived asset is tested for recoverability and the undiscounted estimated future cash flows expected to result from the use and eventual disposition of the asset is less than the carrying amount of the asset, the asset is adjusted to fair value and an impairment loss is recognized as the amount by which the carrying amount of a long-lived asset exceeds its fair value. No asset impairment was recognized during the years ending June 30, 2012 and 2011.

Capitation:
The Center has arrangements with various Health Maintenance Organizations (HMOs) to provide medical services to participating Medi-Cal and Healthy Family patients. Under these arrangements, the Center receives monthly per month per member capitation payments, regardless of services actually performed by the Center. The HMOs may also make fee-for-services payments to the Center for certain carved out services based upon discounted fees.

NOTE 2: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

Third-Party Contractual Agreements:
The Center has agreements with Medicare that provide payments under a cost-based reimbursement system and with Medi-Cal that provide payments under the Prospective Payment System (PPS). In the case of Medicare, reasonable estimates are made and reported in the period services are rendered and differences between the estimates and actual receipts are included in the statement of operations and changes in net assets in the period in which they are determined. In the case of Medi-Cal, payments under the new system are final unless the number of reimbursable visits is changed as a result of an audit by the California Health and Human Services Agency. In addition, under the Medi-Cal PPS, the Center may apply for a change-in-scope of services annually. This process may result in additional Medi-Cal reimbursements for the Center.

Charity Care:
The Center provides care to patients, who meet certain criteria under its sliding fee policy, without charge or at amounts less than its established rates. The Center does not pursue collection of amounts determined to qualify as sliding fee care and they are not reported as revenue.

Temporarily and Permanently Restricted Net Assets:
Contributions, including government grants and contracts, are recorded as either temporarily or permanently restricted revenue if they are received with donor stipulations that limit the use of the donated asset. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted assets are reclassified to unrestricted net assets and reported in the statement of operations and changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions expire during the same fiscal year are recognized as unrestricted revenue.

Paid Time Off:
The Center permits its employees to accumulate paid time off (PTO) hours over their working career and to redeem such unused paid time hours in cash upon termination of employment. Vacation benefits may be accumulated to a maximum of 264 hours. Employees earn PTO hours based on length of service. Employees do not earn any additional credit hours until previously accumulated PTO benefits have been used. In the current year, the Center also added the option of allowing Employees to invest a portion of their annual accrued PTO to their 403(b) retirement plan.

Income Taxes:
The Center has been recognized by the Internal Revenue Service as a non-profit corporation as described in Sec. 501(c)(3) of the Internal Revenue Code (IRC) and is exempt from federal and state income taxes on related income pursuant to Sec. 501(a) of the IRC and California Revenue and Taxation code Sec 23701d. However, the Center is subject to income taxes on any net income that is derived from a trade or business, regularly carried on and not in furtherance of the purposes for which it was granted exemption, commonly referred to as unrelated business income. No income tax provision has been recorded for the years ended June 30, 2012 and 2011, since management determined that the Center had no unrelated business income.

The Center determines whether its tax positions are "more-likely-than-not" to be sustained upon examination by the applicable taxing authority based on the technical merits of the positions. As of June 30, 2012, the Center has reviewed its tax positions and has concluded no reserve for uncertain tax positions is required. The Center's open tax years subject to review are 2009-2012 for federal and 2008-2012 for state.

NOTE 2: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

Revenue Recognition:
Patient service revenue is recorded at the Center's established rates adjusted for sliding scale fee discounts, provisions for uncollectible accounts, and third-party contractual allowances to arrive at net service revenue.

Revenue from government grants and contracts restricted for use in specific activities is recognized in the period when expenditures have been incurred in compliance with the grantor's restrictions. Grants and contracts awarded for the acquisition of long-lived assets are reported as unrestricted non-operating revenue, in absence of donor stipulations to the contrary, during the fiscal year in which the assets are acquired. Cash received in excess of revenue recognized is recorded as deferred revenue. Grant activities and outlays are subject to audit and acceptance by the granting agency and, as a result of such audit, adjustments could be required.

Contributions are recognized as revenue when they are received or unconditionally pledged. Donor stipulations that limit the use of the donation are recognized as restricted contributions. When the purpose restriction is accomplished, temporarily restricted net assets are reclassified to unrestricted and reported as net assets released from restrictions.

The Electronic Health Records Incentive Program, enacted as part of the *American Recovery and reinvestment act of 2009*, provides for one-time incentive payments under both the Medicare and the Medicaid program to eligible Centers that demonstrate meaningful use of certified electronic health records technology (EHR). Payments under the Medicare program are generally made for up to six years based upon a statutory formula, as determined by the State which is approved by the Centers for Medicare and Medicaid Services. Payment under both programs are contingent on the Center continuing to meet escalating meaningful use criteria and any other specific requirements that are applicable for the reporting period. The final amount for any payment year is determined based upon and audit by the State, fiscal intermediary or Medicare Administrative Contractor. Events could occur that would cause the final amounts to differ materially from the initial payments under the program. In 2012, the Center completed the first-year requirements and received funds under the Medicaid program and has recorded revenue of approximately $446,250, which is identified as an electronic health records incentive program in the statement of operations.

Bond Issuance Costs:
Bond issuance costs include capitalized financing cost of issuing the Insured Revenue Bonds – 2005 Series A through the California Health Facilities Financing Authority (CHFFA). Amortization of these capitalized financing costs is being computed over the life of the bonds by using the straight-line method.

Reclassifications:
Certain financial statement amounts have been reclassified in these financial statements to conform to the current year's presentation format. These reclassifications have no effect on the previously reported change in net assets.

NOTE 3: DISCLOSURES ABOUT FAIR VALUE OF FINANCIAL INSTRUMENTS

The following methods and assumptions were used by the Center in estimating the fair value of financial instruments:

Cash and Cash Equivalents and Assets Limited As to Use:
The carrying amount reported in the balance sheets for cash and cash equivalents and assets limited as to use approximates its fair value.

Patient Accounts Receivable:
The carrying amount reported in the balance sheets for accounts receivable approximates its fair value.

Inventory and Other Prepaid Expenses:
The carrying amount reported in the balance sheets for inventory and other prepaid expenses approximates its fair value.

Accounts Payable and Accrued Expenses:
The carrying amount reported in the balance sheets for accounts payable and accrued expenses approximates its fair value.

Third-Party Settlements:
The carrying amount reported in the balance sheets for estimated third-party settlements approximates its fair value.

Investment Securities:
Financial Accounting Standards Board's (FASB) Accounting Standard Codification (ASC) 820, *Fair Value Measurements and Disclosures*, requires the fair value of financial assets and liabilities to be determined using a specific fair value hierarchy. The objective of the fair value measurement of financial instruments is to reflect the hypothetical amounts at which the organization could sell assets or transfer liabilities in an orderly transaction between market participants at the measurement date. FASB ASC 820 describes three levels of inputs that may be used to measure fair value:

Level 1
Quoted prices in active markets for identical assets;

Level 2
Observable inputs other than Level 1 prices, such as quoted prices for similar assets; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets;

Level 3
Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets.

Pursuant to FASB ASC 820, the Center's investments are classified within Level 1 and Level 2 of the fair value hierarchy. The types of securities valued based on Level 1 inputs include mutual funds, money market funds, and bonds. The types of securities valued based on Level 2 inputs include certificates of deposit, fixed income and stocks.

NOTE 3: DISCLOSURES ABOUT FAIR VALUE OF FINANCIAL INSTRUMENTS (continued)

The following table presents financial instruments measured at fair value on a recurring basis in accordance with FASB ASC 820 as of June 30, 2012 and 2011:

		June 30, 2012 Fair Value Measurement Using		
	Fair Value	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Other Unobservable Inputs (Level 3)
Mutual funds	$1,302,634	$1,302,634		
Certificates of deposit	3,339,368		$3,339,368	
Money market funds	444,353	444,353		
Fixed income	3,047,063		3,047,063	
Stock	2,625		2,625	

		June 30, 2011 Fair Value Measurement Using		
	Fair Value	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Other Unobservable Inputs (Level 3)
Mutual funds	$1,492,069	$1,492,069		
Certificates of deposit	1,200,000		$1,200,000	
Money market funds	710,528	710,528		
Bonds	357,412	357,412		
Fixed income	3,613,324		3,613,324	
Stock	2,625		2,625	

NOTE 4: THIRD-PARTY SETTLEMENTS RECEIVABLE

As of June 30, 2012 and 2011, the Center has recorded a receivable due from government payors of $799,813 and $894,439, respectively. The years that are still open and subject to final audit by the third party government payors are 2009 through 2012. In July 2011 the Center received payments from Medi-Cal in the amount of $847,282. In the opinion of management, final settlement of the associated cost reports and PPS reconciliations will not materially affect the financial statements of the Center.

NOTE 5: ASSETS LIMITED AS TO USE

As of June 30, 2012 and 2011, assets limited as to use consisted of assets held by the trustee under the Insured Revenue Bonds – 2005 Series A and 457(b) deferred compensation as follows:

	2012	2011
Deferred compensation benefit plan -457(b)	$ 1,530,270	$ 1,734,454
Revenue Bonds -2005 Series A	426,404	449,418
Total assets limited as to use	1,956,674	2,183,872
Less: current portion	(68,274)	(91,288)
Total net assets limited as to use	$ 1,888,400	$ 2,092,584

NOTE 6: PATIENT ACCOUNTS RECEIVABLE, NET

Net patient accounts receivable are comprised of the following payors as of June 30, 2012 and 2011:

	2012	2011
Medi-Cal and other related products	$ 2,990,209	$ 968,054
Medicare	716,143	565,152
Insurance and other third-party payors	2,404,435	1,935,616
Private pay patients	5,152,297	5,932,940
Total before allowance for doubtful accounts	11,263,084	9,401,762
Less: allowance for doubtful accounts	(9,610,319)	(7,338,041)
Total net patient accounts receivable	$ 1,652,765	$ 2,063,721

NOTE 7: CONCENTRATIONS OF CREDIT RISK

The Center grants credit without collateral to its patients, most of whom are local residents and are insured under third-party agreements. The mix of receivables from third-party payors and patients as of June 30, 2012 and 2011, is as follows:

Payor Class	2012	2011
Medi-Cal	27%	10%
Medicare	6%	6%
Insurance and other third-party payors	21%	21%
Private pay patients	46%	63%
Total	100%	100%

NOTE 8: PATIENT SERVICE REVENUE, NET

The Center has agreements with third-party payors that provide payments to the Center at amounts different from its established rates. A summary of the payment agreements with third-party payors follows:

Medi-Cal: Medi-Cal and dental services rendered to Medi-Cal beneficiaries are paid under the Prospective Payment System (PPS) using rates established by the Center's "Base Year" cost report filed under the previous cost-based reimbursement system. These rates are adjusted annually according to changes in the Medicare Economic Index and any approved changes in the Center's scope of service.

Medicare: Medi-Cal services rendered to Medicare program beneficiaries are paid under a cost-based reimbursement system, not to exceed a predetermined upper limit. The Center is reimbursed at a tentative (interim) rate, with final settlement determined after submission of the annual cost report by the Center and audit thereof by the fiscal intermediary.

Insurance: The Center has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the Center under these agreements includes prospectively determined rates and discounts from established charges.

Capitation: The Center has also entered into agreements for capitated patients for which the Center receives a fixed amount per month per member to take care of member's primary medical care.

NOTE 9: PROPERTY, BUILDINGS, AND EQUIPMENT

Property, buildings, and equipment, as of June 30, 2012 and 2011, are comprised of the following:

	2012	2011
Land	$ 242,272	$ 242,272
Buildings	2,529,713	2,529,712
Leasehold improvements	1,078,945	1,634,386
Equipment	3,046,795	3,619,037
Total depreciable assets	6,897,725	8,025,407
Less: Accumulated depreciation	(1,969,077)	(3,721,630)
Total net depreciable assets	4,928,648	4,303,777
Construction-in-progress	-	440,035
Total property, buildings, and equipment	$ 4,928,648	$ 4,743,812

Depreciation expense for the year ended June 30, 2012 and 2011 is $639,455 and $590,195, respectively. The Center has committed to various construction and renovation projects as of June 30, 2011 relating to the Gleason House project and the Mariposa Project. Both the Gleason House and the Mariposa Project were completed and placed into operations as of June 30, 2012. Fully depreciated assets no longer in operating were removed from the Center's records and only items meeting the capitalization policy were capitalized and recorded as assets as of June 30, 2012.

NOTE 10: GRANTS AND OTHER RECEIVABLES

Grants and other receivables are comprised of grants from federal, state, county, and other granting agencies. As of June 30, 2012 and 2011, the grants and other receivables were comprised of the following:

	2012	2011
Grants receivable:		
Federal grant receivable	$ 594,798	$ 108,710
Women, Infant and Children (WIC) grant receivable	542,112	362,384
Other grant receivable	166,185	56,910
Other receivables:		
Pharmacy receivable	130,277	118,200
Other receivable	295,700	49,168
Total grants and other receivables	$ 1,729,072	$ 695,372

NOTE 11: ACCRUED PAYROLL AND RELATED LIABILITIES

The balance of accrued payroll and other expenses as of June 30, 2012 and 2011 is comprised of the following:

	2012	2011
Accrued payroll	$ 1,110,393	$ 1,018,224
Accrued paid time off	1,136,286	1,084,051
Accrued other payroll benefit liabilities	1,710,270	1,734,454
Total accrued payroll and other related liabilities	$ 3,956,949	$ 3,836,729

NOTE 12: DONATED SERVICES, MATERIALS, FACILITIES, AND OTHER

Donated services are those services that have been received, valued, and recorded. Contributed services are those services that are received but not valued or recorded. The Center reports gifts of cash and other assets as restricted support if received with donor stipulations that limit the use of the donated assets. When a donor restriction expires (that is, when a stipulated time restriction ends or a purpose restriction is accomplished), temporarily restricted net assets are reclassified as unrestricted net assets and reported in the statement of operations and change in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reflected as unrestricted contributions in the accompanying financial statements. Absent donor-imposed restrictions, the Center records donated services, materials, and facilities as unrestricted support. It is the policy of the Center to encourage contributions.

NOTE 13: DEFERRED REVENUE

The Center has received federal, state, and other funds in the form of grants, which are subject to review and audit by the grantor agencies. Additionally, funds received in advance of their corresponding expenditure are considered to be refundable until such expenditure is incurred. Revenue recognition is also deferred until expenditures are realized. For the years ended June 30, 2012 and 2011, deferred revenue was as follows:

	2012	2011
Kaiser Foundation Health grant	$ 21,567	$ 108,049
Sutter Health grant	4,669	94,836
Blue Shield grant	3,333	6,667
Catholic Healthcare West grant	52,537	-
Other grants (non-federal)	16,671	54,142
Total deferred revenue	$ 98,777	$ 263,694

NOTE 14: LEASE COMMITMENTS

Operating Leases
The Center has commitments under operating lease agreements for medical space in Tracy, Dixon, Stockton, Lodi, and Vacaville, California. The leases range in termination dates from the years ended 2013 through 2020. The Center also has equipment leases which range in termination dates from years ending 2009 through 2013. Total lease expense for the years ended June 30, 2012 and 2011 was $1,072,538 and $1,033,639, respectively. The following are the estimated lease commitments based on agreements in place at June 30, 2012:

Year Ending	Lease Payment
2013	$ 992,591
2014	710,824
2015	474,901
2016	443,687
2017	37,201
Thereafter	64,201
Total	$2,723,405

NOTE 15: LONG-TERM DEBT

Debt borrowings consist of bonds payable refinanced through the California Health Facilities Financing Authority Refunding Revenue Bonds 2005 Series A. The full bond offering by the California Health Facilities Financing Authority was $22,545,000.

The bonds consist of serial, term, and variable rate bonds maturing in varying amounts from 2008 through 2022 and bear interest at rates ranging from 3.5% to 5%. The bond proceeds were used to redeem the 1994 Series B bonds and finance capital improvements. The 1994 Series B bonds were redeemed in October 2005 at 102% of the outstanding principal of $2,580,000.

The 2005 Series A bonds are secured by the gross revenues of the Center. Interest expense relating to these bonds was $113,856 and $118,041 for the years ended June 30, 2012 and 2011, respectively. Principal payments are due each April 1.

The balance outstanding as of June 30, 2012 and 2011 are as follows:

	2012	2011
California Health Facilities Financing Authority - 2005 Series A - Bonds	$ 2,285,000	$ 2,445,000
Less: Current portion	(165,000)	(160,000)
Total long-term debt	$ 2,120,000	$ 2,285,000

Future principal payments are as follows for the years ended June 30:

Year	Principal
2013	$ 165,000
2014	170,000
2015	175,000
2016	185,000
2017	195,000
Thereafter	1,395,000
Total	$ 2,285,000

As of June 30, 2012 and 2011, the Center is in compliance with all financial debt covenants.

NOTE 16: SLIDING FEE DISCOUNTS (CHARITY CARE)

The Center's charity care is offered through sliding fee discounts under various grant agreements. The amount of sliding fee discounts and other forms of uncompensated care for the years ended June 30, 2012 and 2011 was approximately $6,421,000 and $6,553,000, respectively. These amounts were determined by calculating the number of sliding fee patients below the 201% federal poverty guidelines times the average cost per patient less projected payments received from patients and grants for charity care.

The grant funds received as of June 30, 2012 and 2011, to assist with providing this care was primarily received from the U.S. Department of Health and Human Services, through the Bureau of Primary Care Community Health Center Cluster–Section 330 funds in the amount of $4,259,012 and $3,898,588, respectively.

NOTE 17: MEDICAL MALPRACTICE CLAIMS

The Center, including officers, governing board members, employees, and contractors who are physicians or other licensed or certified health care practitioners, is covered under the Federal Tort Claims Act (FTCA) which is available to clinics funded under §330 of the Public Health Service Act. The Center has been deemed to be a federal agency for the purposes of §224 of the FTCA. The Center also has supplemental professional liability coverage for individual claims up to $1,000,000 and aggregate annual claims up to $3,000,000.

Accounting principles generally accepted in the United States of America require a health care provider to accrue the expense of its share of malpractice claim costs, if any, for any reported and unreported incidents of potential improper professional service occurring during the year by estimating the probable ultimate costs of the incidents. Based upon the Center's claim experience, no such accrual has been made and there are no known claims or incidents that may result in the assertion of additional claims as of the date of this report. It is reasonably possible that this estimate could change materially in the near term.

NOTE 18: RETIREMENT PLANS

All employees are eligible to enroll in the Center's 403(b) ERISA retirement savings plan upon employment and make pre-tax deferrals of their pay. Employees may contribute into the retirement plan up to the maximum allowed under the regulations. The maximum annual contribution is based on a percent of salary, age of employee, and number of years with the Center. The Center contributes an amount equal to 25% of the first 6% of the employee's deferral after twelve months of employment.

The Center also offers eligible employees a 457(b) retirement plan pursuant to Section 457(b) of the Internal Revenue Code of 1986, as amended. The purpose of the plan is to provide deferred compensation payments for designated employees. The Center contributes an amount equal to 25% of the first 6% of the employee's deferral or an amount determined by the Board of Directors upon review.

Contributions to the plans for the years ended June 30, 2012 and 2011 amounted to $216,703 and $187,830, respectively.

NOTE 19: CONTINGENCIES

Continuing program funding from federal and state sources is contingent upon availability of funds and project performance. The funds are awarded on a yearly basis upon receipt and approval of program applications. In addition, expenses made under federal and state grants are subject to review and audit by the grantor agencies.

Laws and regulations governing Medicare and Medi-Cal programs are complex and subject to interpretation. The Center believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoings. While no such regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medi-Cal programs.

The Center may from time to time be involved in litigation and regulatory investigations, which arise in the normal course of doing business. After consultation with legal counsel, management estimates that matters existing as of June 30, 2012, will be resolved without material adverse affect on the Center's future financial position, results of operations, or cash flows.

NOTE 20: FUNCTIONAL EXPENSES

The Center provides health care services primarily to residents within its geographic area. Expenses related to providing these health care services are as follows:

	2012	2011
Health care services	$34,609,916	$31,348,393
General and administrative	5,746,808	4,972,337
Total expenses	$40,356,724	$36,320,730

NOTE 21: RELATED PARTIES

A board member of the Center is also the landlord for one of the Center's downtown Stockton locations currently housing the Women, Infants, and Children (WIC) Supplemental Nutrition Program. The total amount of rent paid for each year ending June 30, 2012 and 2011 was $33,360. The rent per sq. ft. is $0.875.

NOTE 22: SUBSEQUENT EVENTS

Subsequent events are events or transactions that occur after the statement of operations and changes in net assets date but before the financial statements are available to be issued. The Center recognizes in the financial statements the effects of all subsequent events that provide additional evidence about conditions that existed at the date of the statement of operations and changes in net assets, including the estimates inherent in the process of preparing the financial statements. The Center's financial statements do not recognize subsequent events that provide evidence about conditions that did not exist as of the date of the statement of operations and changes in net assets but arose after the balance sheet date and before the financial statements are available to be issued.

The Center has evaluated subsequent events through November 5, 2012, which is the date the financial statements were available to be issued. No other events were identified impacting the accompanying financial statements and disclosures.

SINGLE AUDIT REPORTS

COMMUNITY MEDICAL CENTERS, INC.

For the year ended June 30, 2012

FHG PARTNERS, LLP
CERTIFIED PUBLIC ACCOUNTANTS

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Independent Auditor's Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance With Government Auditing Standards

Board of Directors
Community Medical Centers, Inc.
Stockton, California

We have audited the financial statements of Community Medical Centers, Inc. as of and for the year ended June 30, 2012, and have issued our report thereon dated November 5, 2012. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States.

Internal Control Over Financial Reporting

Management of Community Medical Centers, Inc. is responsible for establishing and maintaining effective internal control over financial reporting. In planning and performing our audit, we considered Community Medical Centers, Inc.'s internal control over financial reporting as a basis for designing our auditing procedures for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of Community Medical Centers, Inc.'s internal control over financial reporting. Accordingly, we do not express an opinion on the effectiveness of Community Medical Centers, Inc.'s internal control over financial reporting.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A *material weakness* is a deficiency, or combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis.

Our consideration of internal control over financial reporting was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over financial reporting that might be deficiencies, significant deficiencies or material weaknesses. We did not identify any deficiencies in internal control over financial reporting that we consider to be material weaknesses, as defined previously.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether Community Medical Centers, Inc.'s financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Board of Directors
Community Medical Centers, Inc.
Stockton, California

We noted certain matters that we reported to management of Community Medical Center, Inc. in a separate letter dated November 5, 2012.

This report is intended solely for the information and use of management, Chief Executive Director, Chief Financial Officer, Chief Operating Officer, the Board of Directors, others within the entity, and Federal and State awarding agencies, and pass-through entities and is not intended to be and should not be used by anyone other than these specified parties.

FHG Partners, LLP

Visalia, California
November 5, 2012

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CERTIFIED PUBLIC ACCOUNTANTS

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Independent Auditor's Report on Compliance With Requirements That Could Have a Direct and Material Effect on Each Major Program and on Internal Control Over Compliance in Accordance With OMB Circular A-133

Board of Directors
Community Medical Centers, Inc.
Stockton, California

Compliance

We have audited Community Medical Centers, Inc.'s compliance with the types of compliance requirements described in the *U.S. Office of Management and Budget (OMB) Circular A-133 Compliance Supplement* that could have a direct and material effect on each of Community Medical Centers, Inc.'s major federal programs for the year ended June 30, 2012. Community Medical Centers, Inc.'s major federal programs are identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs. Compliance with the requirements of laws, regulations, contracts, and grants applicable to each of its major federal programs is the responsibility of Community Medical Centers, Inc.'s management. Our responsibility is to express an opinion on Community Medical Centers, Inc.'s compliance based on our audit.

We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. Those standards and OMB Circular A-133 require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about Community Medical Centers, Inc.'s compliance with those requirements and performing such other procedures, as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion. Our audit does not provide a legal determination of Community Medical Centers, Inc.'s compliance with those requirements.

In our opinion, Community Medical Centers, Inc. complied, in all material respects, with the compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the year ended June 30, 2012. However, the results of our auditing procedures disclosed instances of noncompliance with those requirements, which are required to be reported in accordance with OMB Circular A-133 and which are described in the accompanying schedule of findings and questioned costs as items 2012-01 through 2012-04.

Internal Control Over Compliance

Management of Community Medical Centers, Inc. is responsible for establishing and maintaining effective internal control over compliance with the requirements of laws, regulations, contracts, and grants applicable to federal programs. In planning and performing our audit, we considered Community Medical Centers, Inc.'s internal control over compliance with the requirements that could have a direct and material effect on a major federal program to determine the auditing procedures for the purpose of expressing our opinion on

compliance and to test and report on internal control over compliance in accordance with OMB Circular A-133, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of Community Medical Centers, Inc.'s internal control over compliance.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be deficiencies, significant deficiencies, or material weaknesses. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses, as defined above. However, we identified certain deficiencies in internal control over compliance that we consider to be significant deficiencies as described in the accompanying schedule of findings and questioned costs as items 2012-01 through 2012-04. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Community Medical Centers, Inc.'s responses to the findings identified in our audit are described in the accompanying schedule of findings and questioned costs. We did not audit Community Medical Centers, Inc.'s responses and, accordingly, we express no opinion on the responses.

This report is intended solely for the information and use of management, Chief Executive Officer, Chief Financial Officer, Chief Operating Officer, the Board of Directors, and others within the entity, Federal and State awarding agencies, and pass-through entities and is not intended to be and should not be used by anyone other than these specified parties.

FHG Partners, LLP

Visalia, California
November 5, 2012

SUPPLEMENTARY SCHEDULES

COMMUNITY MEDICAL CENTERS, INC.

For the year ended June 30, 2012

COMMUNITY MEDICAL CENTERS, INC.
Schedule of Expenditures of Federal Awards
For the year ended June 30, 2012

Federal Grantor/Program Title	Federal CFDA Number	Expenditures
U.S. Department of Health and Human Services:		
Direct:		
Community Health Center Cluster - Section 330	93.224*	$ 4,259,012
Early Intervention Services with Respect to HIV Disease Ryan White - Part C Outpatient EIS Program	93.918*	374,641
ARRA - Capital Improvement Program	93.703*	860,823
Health Care and Other Facilities	93.887	84,221
Pass-through:		
Central Valley Collaborative		
CalHIPSO-Health Information Technology Regional Extension Centers Program	93.718	59,366
County of Solano		
HIV Care Formula Program	93.917	50,000
Total U.S. Department of Health and Human Services		5,688,063
Department of Housing and Urban Development:		
Pass-through:		
City of Stockton		
Community Development Block Grants/Entitlement Grants	14.218	119,010
County of San Joaquin		
Community Development Block Grants/Entitlement Grants	14.218	51,004
Total Department of Housing and Urban Development		170,014
United States Department of Agriculture:		
Pass-through:		
State of California Department of Health Services Women, Infants, and Children (WIC) Supplemental Nutrition Program	10.557*	1,254,907
Total federal financial assistance		$ 7,112,984

*Denotes Major Program

See accompanying Notes to the Schedule of Expenditures of Federal Awards

COMMUNITY MEDICAL CENTERS, INC.
Notes to the Schedule of Expenditures of Federal Awards
For the year ended June 30, 2012

NOTE A: BASIS FOR PRESENTATION

The accompanying schedule of expenditures of federal awards "the Schedule" summarizes the expenditures of Community Medical Centers, Inc. "the Center" under programs of the federal government for the year ended June 30, 2012. Because the Schedule presents only a selected portion of the operations of the Center, it is not intended to, and does not, present the statements of financial position, activities, or cash flows for the Center.

For purposes of the Schedule, federal awards include all grants and contracts entered into directly between the Center, agencies, and departments of the federal government. The awards are classified into major program categories in accordance with the provisions of Office of Management and Budget (OMB) Circular A-133, *Audits of States, Local Government, and Non-Profit Organizations*.

NOTE B: BASIS OF ACCOUNTING

For purposes of the Schedule, expenditures for federal programs are recognized on the accrual basis of accounting. Expenditures are determined using the cost accounting principles and procedures set forth in OMB Circular A-122, *Cost Principles for Non-Profit Organizations*.

NOTE C: RELATIONSHIP OF SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS TO THE FINANCIAL STATEMENTS

Consistent with management's policy, federal awards are recorded in various revenue categories. As a result, the amount of total federal awards expended on the Schedule does not agree to total grant revenue on the statement of operations and changes in net assets as presented in the Center's audited financial statements.

NOTE D: SUBRECIPIENT'S

The Center did not provide any federal awards to a sub-recipient during the year ended June 30, 2012.

COMMUNITY MEDICAL CENTERS, INC.
Schedule of Findings and Questioned Costs
For the year ended June 30, 2012

I. SUMMARY OF AUDITOR'S RESULTS

FINANCIAL STATEMENTS

Type of auditor's report issued	Unqualified	
Internal Control over financial reporting: Material weakness(es) identified?	_____ yes	__X__ no
Significant deficiency(ies) identified ?	_____ yes	__X__ none reported
Noncompliance material to financial statements noted?	_____ yes	__X__ no

FEDERAL AWARDS

Internal control over major programs: Material weakness(es) identified?	_____ yes	__X__ no
Significant deficiency(ies) identified?	__X__ yes	_____ none reported
Type of auditor's report issued on compliance for major programs	Unqualified	
Any audit findings disclosed that are required to be reported in accordance with Section 510(a) of OMB Circular A-133?	__X__ yes	_____ no

Identification of major programs:	CFDA Number
U.S. Department of Health and Human Services:	
Community Health Center Cluster - Section 330	93.224
Early Intervention Services with Respect to HIV Disease Ryan White - Part C Outpatient EIS Program	93.918
ARRA - Capital Improvement Program	93.703
Department of Health Services Women, Infants, and Children (WIC) Supplemental Nutrition Program	10.557

Dollar threshold used to distinguish between type A and type B programs:	$ 300,000	
Auditee qualified as low-risk auditee?	_____ yes	__X__ no

II. FINANCIAL STATEMENT FINDINGS

None Reported

III. FEDERAL AWARD FINDINGS AND QUESTIONED COSTS

Reference Number | **Finding**

2012-01 **Sliding Fee – Eligibility**

Agency: U.S. Department of Health and Human Services
CFDA Number: 93.224
Program: Community Health Center Cluster - Section 330
Compliance Requirement: E. Eligibility

Criteria: Grant compliance provisions require that the Center correctly identify a patient's ability to pay and that the rates for services be adjusted accordingly based on the sliding fee schedule. The Center is required to follow its sliding fee policy when providing discounts to eligible patients.

Condition/ Context: Ten cases from the sample of twenty tested, were found to be deficient for either not being able to verify the family size, or the sliding fee assigned in the computer was incorrect, or the monthly income was not supported by actual income backup information, or the computer system did not adjust the sliding fee.

Questioned Costs: None

Effect: Lack of strict enforcement of the regulation of sliding fee eligibility determination and compliance resulted in Community Medical Centers, Inc. providing discounted services to beneficiaries greater than the appropriate amounts or not at all when a patient qualified.

Cause: Policy and procedures are well documented and currently maintained with current poverty guidelines; however, turnover of staff and a new computer system that was not set up to automate the process has led to inaccurate calculations and missed documentation. Staff has experienced a significant amount of change with two different patient registration systems in the last couple years. Training on new system and quality improvement not yet developed to ensure compliance and staff training.

Recommendation: The Center's management develop a quality control review process and at least on a monthly or, at a minimum, quarterly basis, select a sample and test the sliding fee discount determinations and calculations. A system review should be done to ensure all appropriate system applications are automated to minimize manual interaction and increase compliance. Negative occurrences should be documented and actions taken to enhance the staff's accuracy of determinations and discount calculations.

Client's Response: The Center is aware of the requirement for improvement in this area and management will implement a quality improvement process and randomly select a sample on a monthly/quarterly basis to ensure staff is trained and accurately calculating the sliding scale fee and that proper documentation supporting patient's payment status are maintained on file.

III. FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (continued)

Reference Number	Finding

2012-02 **Reporting**

Agency: U.S. Department of Health and Human Services
CFDA Number: 93.224, 93.887 and 93.918
Program: Community Health Center Cluster - Section 330 Health Care and Other Facilities
Early Intervention Services with Respect to HIV Disease Ryan White
Compliance Requirement: L. Reporting

Criteria: Grant compliance provisions require that the Center complete certain reports within a given time frame. Based on review of the Center's Electronic Hand Book (EHB) system and other correspondence with the granting agency, the Center did not submit numerous required reports when they were due.

Condition/ Context: Required reporting terms and conditions were not being monitored and reports were not filed on time. These reporting requirements were part of the grant's terms and conditions.

Questioned Costs: None

Effect: Not complying with the terms and conditions of the grants.

Cause: Lack of accountability and no master calendar of due dates being maintained.

Recommendation: The Center's management should consider maintaining a master calendar with all due dates for grant reporting. Fiscal staff should develop as part of their month end financial close a process to comply with all required reporting for the month.

Client's Response: The Center is aware of the requirement for reporting and will develop a process to better monitor and ensure compliance with all necessary grant reporting and is working with the granting agency staff to comply with the late report or has requested and been granted an extension for some of the reports.

III. FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (continued)

Reference Number | **Finding**

2012-03 **Eligibility -Homeless Patients**

Agency: U.S. Department of Health and Human Services
CFDA Number: 93.224
Program: Community Health Center Cluster - Section 330- Homeless funding
Compliance Requirement: E. Eligibility

Criteria: In general, the objective of the Consolidated Health Centers Program (CHCP) is to provide to populations that would ordinarily not have access to health care (1) primary and preventive health services, (2) referrals to other services, such as hospital and substance abuse services, and (3) case management and other services designed to assist health center patients in establishing eligibility and gaining access to Federal, State, and local programs that provide additional medical, social, or educational support or enabling services, such as transportation, translation and outreach services, and patient education services. Some health center delivery sites serve vulnerable populations, including homeless individuals, migrant farm workers; however, the center must see these patients at any of their sites.

Condition/ Context: Currently, the Center has developed a specific site for their homeless patients called Carelinks. Homeless patients that do not go to their Carelinks site specifically are not identified as homeless, and accordingly, the Center is not giving themselves credit for the total number of homeless patients they have seen. The Center is identifying the patients as self pay and adjusting the charges as bad debt instead of using appropriate of sliding fee. The sliding fee policy does not reflect the language of the Carelink's application; for example, the form has a box marked as "other" that is to be marked if the patient has been homeless in the last 12 months. The policy does not list "other" as a qualification for the Carelinks.

Questioned Costs: None

Effect: Incorrect determination of appropriate discounts resulted in Community Medical Centers, Inc., under recording the homeless population the Center is serving, not being consistent with the sliding fee policy administration for homeless patients seen at all sites, and policies not matching the forms.

Cause: Lack of a staff understanding and training of the Carelinks (homeless) program by staff not part of the Carelinks location. Policies and forms not being updated.

Recommendation: The Center's management should review the program for full compliance and train all staff to understand that homeless patients are administered the same way as any other sliding fee patients and should adjust the sliding fee policy documentation/ proof of income requirement for these patients.

Client's Response: The Center's management will develop a plan to address and train staff and monitor through the quality improvement process described under 2012-01.

III. FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (continued)

Reference Number | **Finding**

2012-04 **Sliding Fee - Discount Determination- HIV**

Agency: U.S. Department of Health and Human Services
CFDA Number: 93.918
Program: Early Intervention Services with Respect to HIV Disease Ryan White - Part C Outpatient EIS Program
Compliance Requirement: J. Program Income

Criteria: Grant compliance provisions require that the Center correctly identify a patient's ability to pay and that the rates for services be adjusted accordingly based on the sliding fee schedule. The Center is required to follow its sliding fee policy when providing discounts to eligible patients in compliance with the program requirements.

Condition/ Context: The Center did not update their Sliding HIV/AIDS patient Care Program Federal Poverty Levels Guidelines for the 2011/12 year under audit.

Questioned Costs: None

Effect: Incorrect determination of appropriate discounts for HIV beneficiaries.

Cause: Due to changes in system and administrative staff, the HIV sliding fee policy and appropriate patient application documents were not updated nor provided to the staff.

Recommendation: The Center's management should update the HIV policy level guidelines each year with their sliding fee patients and should develop process to ensure the appropriate forms are provided to the staff and computer systems are updated to reflect an automatic adjudication of the sliding fee based on the approved guidelines. HIV sliding fee patients should be added to the qualified improvement program recommend in finding 2012-01.

Client's Response: The Center is aware of the requirement for improvement in this area and management will implement the necessary changes to improve this process and update the HIV policy with the sliding fee policy each year.

IV. PRIOR YEAR AUDIT FINDINGS AND QUESTIONED COSTS

Prior Year Findings/Recommendations	Status	Additional Comments
2011-01 **CFDA#93.224** **Sliding Fee - Proof of Income and Discount Determination**	**Unresolved**	**See Finding 2012-01**

Prior Year Findings/Recommendations	Status	Additional Comments
2011-02 **CFDA#93.918** **Sliding Fee - Discount Determination**	**Unresolved**	**See Finding 2012-04**